UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

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ERIC L. JEFFRIES,

Plaintiff,

v. No. C-1-02-351

CENTRE LIFE INSURANCE COMPANY, ET AL.,

Defendants.

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DEPOSITION OF CHARLES POSER, M.D., a witness called on behalf of the Defendant, taken pursuant to the provisions of the Massachusetts Rules of Civil Procedure, before Linda Bernis, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Massachusetts, held at the Beth Israel Hospital, 330 Brookline Avenue, Boston, Massachusetts, on Tuesday, July 8, 2003, commencing at 2:00 p.m.

Q. My name is Bill Ellis.
A. I saw him on two occasions. I saw him on June 7, 2000 -- I saw him three times. February 1, 2001 -- no, I'm sorry. That was a telephone conversation. I saw him on May 22, 2002.
Q. Was he referred to you by anyone, to your knowledge, for the June 2000 visit?
A. Yes. He was referred to me by Dr. Byron Hyde, H Y D E, of Ottawa.
Q. How is it that you know Dr. Hyde or Dr. Hyde knows you?
A. We've corresponded for quite a while regarding this particular disease, chronic fatigue syndrome. I met him at a meeting in Dublin on chronic fatigue syndrome which had been organized by Professor Behine several years ago. I think he's referred me, at least, one other case, as I remember. So I've known him for, I don't know, six or seven years probably.
Q. I also have been provided with two reports that you've prepared with regard to Mr. --
A. My original report was to Dr. Hyde on

an ophthalmic specialist and an endocrinologist, correct?

A. Yes.

Q. Did you, in your history, seek to acquire any medical information concerning Mr. Jeffries prior to June of 1997?

A. Except later on, I found out that he had had a football injury 20 years previous, but that was it. No, otherwise, I did not make any attempt to obtain medical information prior to 1997 or '98, no.

Q. The football injury was an injury that dealt with C4, C5 and C6?

A. Yes. He had an MRI of the cervical spine, which, as far as I know, did not show anything particularly significant; at least not in relationship to his complaints.

Q. That MRI would have been taken at the time of the injury back in --

A. No.

Q. It was subsequent?

A. They didn't have MRI then. MRI came out in general use in the later eighties.

Q. Do you know what the date of the MRI was?

that's number seven. Hearing is number eight. Nine is swallowing. 10, he sticks out his tongue. 11, you check his masteroid by pushing against his jaw while he pushes against your hand. 12 is sticking out his tongue. 13 is his speech, which sounded perfectly normal. That's it. Very simple; very quick. It takes about 30 seconds to do that.

Q. Cranial nerve functions were also all normal?

A. Yes.

Q. Equilibrium was normal?

A. His entire neurological examination was normal.

Q. That will save us going through each one individually.

Neurologically, he was normal and intact as of the time you saw him?

A. Yes.

Q. What else did you do besides the neurological examination?

A. I talked to him a great deal about what he was doing, what his problems were, and, in

computed tomography?
A. Something like that.
Q. Basically, what happens is, they inject an isotone into the patient and some time later they have the patient lie down and they scan him with something that picks up a single-photon emission computed tomography coming from the blood flow in the brain; is that right?
A. Right.
Q. And he finds that, or he concluded that the brain scan, or the spec scan, rather, the type of spec scan that he reviewed has been described in relation to different conditions including chronic fatigue; is that right?
A. Yes.
Q. Now, there is no medical literature which suggests that chronic fatigue is, sorry, that spec scans are diagnostic of chronic fatigue; is that right?
A. I really don't know. I don't know. This is something that I have not pursued. This is quite beyond my expertise. I've never used

it. I never referred a patient for a SPECT scan so I don't know. I can't answer that.

Q. In addition to the SPECT scan, he had a PECK scan, which is a photon emission topography?

A. Which I know even less about, to put it bluntly.

Q. Did you ask Dr. Hyde, or anyone else, what other conditions are consistent with the readings in these PECK and SPECT scans?

A. No, I really didn't for the very simple reason, I made my diagnosis of chronic fatigue syndrome based purely on clinical considerations, and the findings on PECK scan and SPECT scan, I would say, are very interesting. How convincing they are, I just don't know. This is not something that I really know much about.

Q. All right.

A. I will not testify about that anyway.

Q. Did you rely upon them in evaluating your diagnosis?

A. No.

Q. We can pass on that.

The next thing you received was

criteria here. No.
Q. Can you check them off for me, the criteria that you would use?
A. That I would use?
Q. Yes. Your criteria?
A. My criteria?
Q. Yes.
A. Okay. I divide them into major symptoms which include fatigue, micro-myalgia, migratory myalgia, migratory painful paresthesia, memory and cognitive disturbance. Those are the major.
Q. I don't write as fast as you talk.
A. They are right here.
Q. Okay. You can keep this.
You have major and minor symptoms that you expect to see in a person with true chronic fatigue syndrome?
A. I can't remember how many of each.
Q. We'll look at them. Major fatigue is one?
A. Yes, obviously.
Q. That fits the definition and diagnosis and the name?
A. Right.

Q. Let's talk about Mr. Jeffries specifically. We know that he complained of fatigue, correct?
A. Yes. Muscle pain.
Q. He complained of muscle pain moving from muscle to muscle?
A. Right.
Q. He complained of arthralgia. He complained of the painful paresthesia, and he complained that he had memory and cognitive disturbance?
A. And sleep problems. And he is allergic to Sulpha.
Q. He is allergic to certain drugs.
Did he tell you also that he had apudoma?
A. No, not specifically. Maybe he missed that or maybe I didn't ask him or both.
Q. Basically, he had all the major symptoms and at least two of the minors?
A. Yes.
Q. And that would be the medications and the sleep disturbance?
A. Yes. And the memory cognitive problems,

which were a big problem for him.
Q. That's one of the majors?
A. Yes.
Q. We know he complained of all the majors right down the line?
A. Yes. But he had not read my paper.
Q. Are you sure?
A. Well, yes.
Q. Are you aware that Mr. Jeffries spends, or had been spending at the time, seven or eight hours at a time researching various illnesses on the Internet?
A. Yes, I do. I'm aware of that. But, you know, that paper was just published. It's not a journal that you will find on everybody's shelf.
Q. No, but you would find it if you went to the Internet on chronic fatigue syndrome and looked up the articles?
MR. SHOEMAKER: Are you talking about before or after he had the symptoms?
Q. I'm talking about, obviously, after the vaccination.
A. I don't know if you could find it on the

to the clinical aspects.

Q. Tell me about your preferred term, or Dr. Behine preferred myalgia encephalitis?

A. Because, I think, the disease is a, I hesitate to term it mild, but, I think, it's a variant of posin infection and posin encephalomyelitis, which means an allergic reaction of the nervous system to the antigen or antigens containing vaccines. As I mentioned to you earlier, the classic disease that precipitates infectious mono. Infectious mono is due to an invasion by the enzyme, but it's not clear if it's due to the invasion of the virus itself or if it's a reaction to the virus, an immune reaction to it. My impression is more that it's an immune response to the virus.

So because of that and because of the fact that in some instances, not Mr. Jeffries, there are changes in the MRI, which are very similar to what you see in a post-infectious or myelitis, like the measles or after vaccination. It's a variety.

As I mentioned before, Mr. Jeffries had mentioned that the symptoms were intermittent. I never did discover what the shortest or longest period of time was, and I don't remember if he testified to that or not. I just don't know. But he did mention the fact that they were intermittent.

He quit working, as I remember, in September of '98. So it was about a year after the vaccination, at which time apparently the symptoms became severe enough. That's as far as I know.

Q. In the medical community, do the debates continue as to the viability of chronic fatigue syndrome, fibromyalgia, whatever you call it, as a viable illness as opposed to complaints?

A. Oh, yes.

Q. Of other illnesses?

A. It's been recognized by the CDC. It's been recognized by the VA. I don't know what other.

Q. But it's like a disease of exclusion as far as diagnosis is concerned?

A. I don't think so.
Q. You don't think so?
A. No. People always get my goat when they say MS is disease of exclusion. Not to me it isn't. I think that you can make the diagnosis on the basis of very specific criteria which we have.

I once made myself very popular when I gave a talk on chronic fatigue syndrome to a bunch of psychiatrists and I didn't realize there were patients in the audience. I made the statement that, in my opinion, 90 percent of patients with chronic fatigue syndrome are crocks. That was not a very popular statement. It happened to be something that I believed, which, of course, makes life very difficult for people like Mr. Jeffries. It's not a disease of exclusion. Now, people think it is and they go through all kinds of things to rule it out.

As you mentioned before, Shea disease, Munchhausen syndrome, that's nonsense; absolute nonsense. It costs a lot

of money to do that. It's not necessary.

What people don't know how to do, Mr. Ellis, is take a history. We don't teach that anymore. MRI is much easier.

Q. Well, the fact remains that the symptoms that fit your criteria are, in fact, in order to fit your criteria are subjective symptoms, the ones the patient has to describe to you?

A. That is the definition of a symptom. You mean, they have no signs?

Q. They have no signs.

A. That's correct.

Q. So, basically, we have a complaint without an objective physiological finding to support it?

A. Right.

Q. And that's true of each of the major and minor symptoms that you described?

A. You're absolutely correct.

Q. I thought that we had an objective sign on one of your minors when we talked about tandem walking, but you said objectively they can do it but subjectively they feel

Q. Is there anything dramatic, in your opinion, doctor, about a fellow who travels from coast to coast, north to south and up to Canada and over to England seeking medical opinion after medical opinion after medical opinion, having the doctors write down opinions but never seeking treatment?
A. He came to me.
Q. Did you provide treatment?
A. Sure.
Q. What was your treatment, doctor?
A. I gave him Myxidium and I gave him Neurotone. At that time, we didn't have Motiphino, the other drug which is much more useful for fatigue.

Yes, I did treat him. I told Byron that I treated him.

Q. Has he continued with the treatment?
A. That's not dramatic.
Q. Has he continued the treatment?
A. No idea.
Q. Has he improved at all?
A. I don't know.
Q. If you coupled an somatization form disorder

their problem.
Q. And that criteria is the one that would permit, as you put it, 90 percent of people complaining of CFS who don't actually have it to be diagnosed with it?
A. Yes, but that is my personal opinion.
Q. I understand that.
And the criteria that you identify are your criteria for making the diagnosis?
A. I used --
Q. Not necessarily accepted by the medical profession?
A. I have no idea. Nor do I care.
Q. Right. I'm with you.
In your experience, do you believe that patients such as Mr. Jeffries with chronic fatigue diagnosed by your criteria will deteriorate over time or do they reach a plateau and just stay that way forever?
A. Some patients recover. It's not very common. Most patients reach a plateau.
I can also tell you, again, in my experience, the disease is more common in women, which is another reason why it's